California Prison Health Care Services
California Department of Corrections & Rehabilitation
Credentialing Application

Provider Name: _____ Today's Date: _____
(Last Name, First Name, Middle Initial)

1. Institution/worksite you are applying for?

_____

2. Which position are you applying for?

_____

3. Are you applying for a civil service or contract position?
   - ☐ Contract
   - ☐ Civil Service

4. This application is an:
   - ☐ Initial Application
   - ☐ 2-Year Reappointment (contact C&PU for direction)
   - ☐ Update/Classification Change
   - ☐ Lateral Transfer from _____

Before submitting your application, please be sure you have completed the following:

- ☐ FULLY complete, sign and date the Credentialing Application. ALL ANSWERS MUST BE SUPPLIED. If there is a portion of the application that does not apply to you, insert Not Applicable or N/A.
- ☐ Ensure ALL fax and telephone numbers requested are accurate.
- ☐ Sign and date the Applicant's Authorization and Release statement.
- ☐ Provide an explanation for ALL "yes" answers to the disclosure questions on page 11 and page 12. The answers may be on a separate sheet of paper as long as it is signed and dated.
- ☐ Provide an explanation for all time gaps three months or greater listed in the work history area.

In addition, please be sure to include copies of the following (as applicable to your licensure):

- ☐ Advanced Cardiac Life Support certificate (provided by American Heart Association) required for Physician & Surgeons, Nurse Practitioners and Physician Assistants
- ☐ Basic Life Support certificate (provided by American Red Cross or American Heart Association) required for Physician & Surgeons, Nurse Practitioners, Physician Assistants, Psychiatrists, and Dentists
- ☐ DEA Certificate
- ☐ National certification from the American Nurses Credentialing Center (ANCC) or the American Academy of Nurse Practitioners (AANP) for Nurse Practitioners
- ☐ Three peer references (initial applications only)
- ☐ Last two years of Continuing Medical Education documentation
- ☐ Medical malpractice insurance coverage (contractors)

You must immediately notify the Credentialing & Privileging Unit of any changes to the information on the application or your licensure status. If you have any questions, please contact the C&PU at (916) 445-1332 or at CAPrisonHCSCreden@cdcr.ca.gov.

APPLICANT'S AUTHORIZATION AND RELEASE

I hereby attest that the information in or attached to this Credentialing application is true and complete. Any misrepresentation, misstatement, or omission from this credentialing profile system, whether intentional or not, may constitute sufficient cause for rejection of this verification resulting in denial of provisional clinical privileges.

I hereby authorize the CDCR, its medical staff, and their representatives to consult with any representative(s) of the medical/professional or administrative staff of any health care organizations with which I have or have had employment, practice, association, or privileges and any other organizations (including without limitation state licensing boards, professional associations, and the National Practitioner Data Bank) or individuals who have information bearing on my credentials, competence, professional performance, clinical skills, judgment, character and ethical qualifications, and to inspect such records that shall be material to the evaluation of my professional qualifications and competence to carry out the privileges I am requesting as well as to my moral and ethical qualifications.

I authorize and request my medical malpractice liability insurance carrier, past and present, to release information to the CDCR, its medical staff, and their representatives regarding any claims or actions for damages pending or closed, whether or not there has been a final disposition.

I hereby release from liability all individuals and organizations that provide said information to the CDCR, medical staff, and their representatives in good faith and without intentional fraud, and I hereby consent to the release of such information.

A photocopy of the release shall be valid as an original. This is a request to obtain additional information, not a commitment to hire.

Please Note: This authorization shall expire upon separation from CDCR or within twelve months of the date below, in the event that no employment is offered and accepted.

_____ _____

Signature of Applicant Date

PRACTICE AND PROFESSIONAL INFORMATION

GENERAL INFORMATION

Provider:

Last Name First Name MI Suffix

List other names by which you have been known:

Last Name First Name MI Start Date End Date

Birth Date: Place of Birth:

(mm/dd/yyyy) City State Country

Gender: ☐ Male ☐ Female

U.S. Citizen? ☐ Yes ☐ No SSN _____

if no:

Do you have a legal right to reside permanently in the U.S.? ☐ Yes ☐ No

Do you have a legal right to work in the U.S.? ☐ Yes ☐ No

Resident Visa No _____

Mailing Address:

Street

City State Zip code

Telephone Number Fax Number Email

PROFESSIONAL LICENSES / IDS

License Type

State | License Number | Exp Date | License Unlimited: ☐ Yes ☐ No

Limitation

License Type

State | License Number | Exp Date | License Unlimited: ☐ Yes ☐ No

Limitation

License Type

State | License Number | Exp Date | License Unlimited: ☐ Yes ☐ No

Limitation

License Type

State | License Number | Exp Date | License Unlimited: ☐ Yes ☐ No

Limitation

License Type

State | License Number | Exp Date | License Unlimited: ☐ Yes ☐ No

Limitation

PROFESSIONAL / MEDICAL SPECIALTY

Primary Specialty

Specialty

Board Certified: ☐ Yes ☐ No

if Yes:

Board Name

Certification Date | Recertification Date | Expiration Date

if No:

Have you taken or are you scheduled to take the board certification? ☐ Yes ☐ No

Date Taken | Date Scheduled

Additional Specialty

Specialty

Board Certified: ☐ Yes ☐ No

if Yes:

Board Name

Certification Date | Recertification Date | Expiration Date

if No:

Have you taken or are you scheduled to take the board certification? ☐ Yes ☐ No

Date Taken | Date Scheduled

PROFESSIONAL LIABILITY INSURANCE

Current Policy

Carrier

Policy Number | Effective Date | Retroactive Date | Expiration Date

Coverage Type | Occurrence Limit | Aggregate Limit

Street

City | State | Zip code

Telephone Number | Fax Number | Email

Coverage Limit Exceeded? ☐ Yes ☐ No

EDUCATION

Education Level | Institution Name

Street

City | State | Zip code

Telephone Number | Fax Number | Email

Degree | Graduation Date | Start Date | End Date

If you are a graduate of a foreign medical school: ECFMG Number | ECFMG Issue Date

Were you the subject of any disciplinary action during you attendance? ☐ Yes ☐ No

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Education Level | Institution Name

Street

City | State | Zip code

Telephone Number | Fax Number | Email

Degree | Graduation Date | Start Date | End Date

If you are a graduate of a foreign medical school: ECFMG Number | ECFMG Issue Date

Were you the subject of any disciplinary action during you attendance? ☐ Yes ☐ No

TRAINING

Type | Institution Name

Street

City | State | Zip code

Telephone Number | Fax Number | Email

Specialty | Start Date | End Date

Department Chair or Program Director:

Last Name | First Name | MI | Degree

Did you successfully complete the program? ☐ Yes ☐ No

Were you the subject of any disciplinary action during you attendance? ☐ Yes ☐ No

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Type | Institution Name

Street

City | State | Zip code

Telephone Number | Fax Number | Email

Specialty | Start Date | End Date

Department Chair or Program Director:

Last Name | First Name | MI | Degree

Did you successfully complete the program? ☐ Yes ☐ No

Were you the subject of any disciplinary action during you attendance? ☐ Yes ☐ No

CURRENT AFFILIATIONS

Type | Institution Name

Street

City | State | Zip code

Telephone Number | Fax Number | Email

Specialty | Start Date

Department / Division | Membership Status

Limitations:

Type | Institution Name

Street

City | State | Zip code

Telephone Number | Fax Number | Email

Specialty | Start Date

Department / Division | Membership Status

Limitations:

PREVIOUS AFFILIATIONS

Type | Institution Name

Street

City | State | Zip code

Telephone Number | Fax Number | Email

Specialty | Start Date | End Date

Department / Division | Membership Status

Limitations:

Type | Institution Name

Street

City | State | Zip code

Telephone Number | Fax Number | Email

Specialty | Start Date | End Date

Department / Division | Membership Status

Limitations:

WORK HISTORY

Work Place

Street

City | State | Zip code

Telephone Number | Fax Number | Email

Position | Start Date | End Date

Work Place

Street

City | State | Zip code

Telephone Number | Fax Number | Email

Position | Start Date | End Date

Work Place

Street

City | State | Zip code

Telephone Number | Fax Number | Email

Position | Start Date | End Date

DISCLOSURE QUESTIONS

Adverse Actions

1.	Has your license to practice in any jurisdiction ever been denied, restricted, limited, suspended, revoked, canceled and/or subject to probation either voluntarily or involuntarily, or has your application for a license ever been withdrawn?	☐ Yes	☐ No
2.	Have you ever been reprimanded and/or fined, been the subject of a complaint and/or have you been notified in writing that you have been investigated as the possible subject of a criminal, civil or disciplinary action by any state or federal agency which licenses providers?	☐ Yes	☐ No
3.	Have you lost any board certification(s), and/or failed to recertify?	☐ Yes	☐ No
4.	Have you been examined by a Certifying Board but failed to pass?	☐ Yes	☐ No
5.	Has any information pertaining to you, including malpractice judgments and/or disciplinary action, ever been reported to the National Practitioner Data Bank (NPDB) and/or any other practitioner data bank?	☐ Yes	☐ No
6.	Has your federal DEA number and/or state controlled substances license been restricted, limited, relinquished, suspended or revoked, either voluntarily or involuntarily, and/or have you ever been notified in writing that you are being investigated as the possible subject of a criminal or disciplinary action with respect to your DEA or controlled substance registration?	☐ Yes	☐ No
7.	Have you, or any of your hospital or ambulatory surgery center privileges and/or membership been denied, revoked, suspended, reduced, placed on probation, proctored, placed under mandatory consultation or non-renewed?	☐ Yes	☐ No
8.	Have you voluntarily or involuntarily relinquished or failed to seek renewal of your hospital or ambulatory surgery center privileges for any reason?	☐ Yes	☐ No
9.	Have any disciplinary actions or proceedings been instituted against you and/or are any disciplinary actions or proceedings now pending with respect to your hospital or ambulatory surgery center privileges and/or your license?	☐ Yes	☐ No
10.	Have you ever been reprimanded, censured, excluded, suspended and/or disqualified from participating, or voluntarily withdrawn to avoid an investigation, in Medicare, Medicaid, CHAMPUS and/or any other governmental health-related programs?	☐ Yes	☐ No
11.	Have Medicare, Medicaid, CHAMPUS, PRO authorities and/or any other third party payors brought charges against you for alleged inappropriate fees and/or quality-of-care issues?	☐ Yes	☐ No
12.	Have you been denied membership and/or been subject to probation, reprimand,sanction or disciplinary action, or have you ever been notified in writing that you are being investigated as the possible subject of a criminal or disciplinary action by any health care organization, e.g. hospital, HMO, PPO, IPA, professional group or society, licensing board, certification board, PSRO, or PRO?	☐ Yes	☐ No
13.	Have you withdrawn an application or any portion of an application for appointment or reappointment for clinical privileges or staff appointment or for a license or membership in an IPA, PHO, professional group or society, health care entity or health care plan prior to a final decision to avoid a professional review or an adverse decision?	☐ Yes	☐ No

Professional Liablility Actions

1.	Have any professional liability judgments ever been entered against you?	☐ Yes	☐ No
2.	Have any professional liability claim settlements ever been paid by you and/or paid on your behalf?	☐ Yes	☐ No
3.	Are there any currently pending professional liability suits, actions and/or claims filed against you?	☐ Yes	☐ No
4.	Has any person or entity ever been sued for your clinical actions?	☐ Yes	☐ No

Liability Insurance

1.	Have you ever been denied or voluntarily relinquished your professional liability insurance coverage, and/or have had your professional liability insurance coverage canceled, non-renewed or limits reduced?	☐Yes	☐ No

Criminal Actions

1.	Have you been charged with or convicted of a crime (other than a minor traffic offense) in this or any other state or country and/or do you have any criminal charges pending other than minor traffic offenses in this state or any other state or country?	☐Yes	☐ No
2.	Have you been the subject of a civil or criminal complaint or administrative action or been notified in writing that you are being investigated as the possible subject at a civil, criminal or administrative action regarding sexual misconduct, child abuse, domestic violence or elder abuse?	☐Yes	☐ No

Medical Conditions

1.	Do you have a medical condition, physical defect or emotional impairment which in any way impairs and/or limits your ability to practice medicine with reasonable skill and safety?	☐Yes	☐ No

Substance Abuse

1.	Are you currently engaged in illegal use of any legal or illegal substances?	☐Yes	☐ No
2.	Do you currently overuse and/or abuse alcohol or any other controlled substances?	☐Yes	☐ No
3.	If you use alcohol and/or chemical substances, does your use in any way impair and/or limit your ability to practice medicine with reasonable skill and safety?	☐Yes	☐ No ☐ N/A
4.	Are you currently participating in a supervised rehabilitation program and/or professional assistance program which monitors you for alcohol and/or substance abuse?	☐Yes	☐ No

Investments

1.	In the last five (5) years have you and/or a member of your family purchased or made an investment in (other than securities of a publicly traded company), or otherwise have a business interest in any clinical laboratory, diagnostic or testing center, hospital, surgicenter, and/or other business dealing with the provision of ancillary health services, equipment or supplies?	☐Yes	☐ No

BUSINESS INFORMATION

SITE INFORMATION

Group / Practice Name | Building Name

Street

City | County | State | Zip code

Telephone Number | Fax Number | Email

Emergency Number | Answering Service | Pager

Mailing Address:

Name of Business Arrangement On SS4 or W-9 Form | Building Name

Street

City | State | Zip code

Billing Information:

Name of Business Arrangement On SS4 or W-9 Form | Building Name

Street

City | State | Zip code

Telephone Number | Fax Number | Tax Id

Administrator:

Last Name | First Name | MI

Telephone Number | Fax Number | Email

Group / Practice Name: _____

Credentialing Manager:

_____
Last Name First Name MI

_____ _____ _____
Telephone Number Fax Number Email

Nurse Manager:

_____
Last Name First Name MI

_____ _____ _____
Telephone Number Fax Number Email

Building Accessibility:

Public transportation? ☐ Yes ☐ No 24 hour number? ☐ Yes ☐ No

Lab Services:

_____ _____ _____
Certificate Type Certificate Number Certificate Expiration Date

Handicap Accessibility / Services:

Building?	☐ Yes ☐ No	Parking?	☐ Yes ☐ No
Wheelchair?	☐ Yes ☐ No	Restroom?	☐ Yes ☐ No
Sign Language?	☐ Yes ☐ No	ADA?	☐ Yes ☐ No

TDD Number: _____

Additional Services:

Languages:

Group / Practice Name: _____

Specialty at this site: _____

Accepting All New Patients?	☐ Yes	☐ No
Accepting New Patients by Referral?	☐ Yes	☐ No
Accepting New Medicare?	☐ Yes	☐ No
Accepting New Medicaid?	☐ Yes	☐ No

Practice Restrictions / Limitations:

Group / Practice Name: _____

Coverage:

Last Name | First Name | MI | Degree

Specialty | Telephone Number

Street

City | State | Zip code

Coverage:

Last Name | First Name | MI | Degree

Specialty | Telephone Number

Street

City | State | Zip code

Coverage:

Last Name | First Name | MI | Degree

Specialty | Telephone Number

Street

City | State | Zip code

Coverage:

Last Name | First Name | MI | Degree

Specialty | Telephone Number

Street

City | State | Zip code

Application Return Methods

Regular Mail:
California Prison Health Care Services
Credentialing and Privileging Unit
PO Box 4038, Suite 315
Sacramento, CA 95812-4038

Overnight Mail:
California Prison Health Care Services
Credentialing and Privileging Unit
510 I Street, Suite 315
Sacramento, CA 95814

Facsimile:
(916) 324-6633 Attn: Credentialing and Privileging Unit

Email:
CAPrisonHCSCreden@cdcr.ca.gov